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Recommended Citation

Vakani, F. S., Jafri, W., Jafri, F., Ahmad, A. (2012). Towards a competency-based postgraduate medical education. *Journal of College of Physicians and Surgeons Pakistan*, 22(7), 476-7.

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Towards a Competency-Based Postgraduate Medical Education

Farhan Vakani¹, Wasim Jafri¹, Fatima Jafri² and Amina Ahmad³

Postgraduate medical education (PGME) is a huge health enterprise that engages hundreds and thousands of faculties and residents.¹ Innovations, successes and readiness to safe practice are possible simply with the growth of PGME. It is a high-stake and important stage of medical education in which trainees progress to develop their competencies and capabilities, and receive the appropriate clinical exposure and training under the guidance of senior and experienced colleagues.² Worldwide, the competency movement is not new and call for it goes back some 60 years or even more since Flexner's report 1910.³ Decades of recurrent calls has therefore, set the precedent for competency-based education.⁴ Also, there seems to be an international agenda that drove this competency movement to have outcomes-based on data for informed discussions and decision-making.⁴ The purpose of discussion is two-fold: analysing a competency-based framework and possibility of its application in postgraduate medical education in Pakistan.

Internationally, paradigm shift from Flexner to competencies in PGME was influenced by the release of the ACGME (Accreditation Council for Graduate Medical Education) project,⁵ CanMEDS (Canadian Medical Education Directions for Specialists) roles,⁶ and others.¹ Worldwide, several countries are moving towards introduction and incorporation of the competencies in PGME.^{1,7} Traditional training models were structured around time frames and curricular processes, regardless of product of the programs.^{5,8} Emphasis was mainly given to the basic understanding of the principles and concepts rather than quality,⁸ and the work roles were broken down into smaller tasks, ignoring the relations between the tasks and the performances. This approach does restrict the residents, limiting and demotivating them to perform the task for scoring to pass the exams.⁸ Unfortunately, the residents were assessed by the number of procedures performed, regardless of correct attempt and patient safety.⁹ Furthermore, till-date the Flexner model is sometimes used where rigid protocols

are to be followed in training, 'hybrid model'.⁸ In contrast to the traditional model, competency-based training simply defines a physician with the desired competencies to effectively practice in their specialties. It replaces the traditional approach of training residents for a fixed number of years to flexible training, transparent standards and increased accountability to public. In competency-based education, the competency of a learner is measured on the basis of the performance or competencies achieved, and not on the period served or underlying processes. A resident is defined as competent when he/she acquires the required skills and knowledge, attitudes and behaviours and is able to apply them safely, independently and competently to individual patients.^{5,8,10} The Oxford Dictionary of English simply defines competency as "the quality or ability to do something correctly."¹¹ Review of literature has shown a number of definitions, when compiled and synthesized, marks competency as an observable ability of a resident to perform, integrate knowledge, skills or attitudes.^{3-6,12} Unlike traditional process-based models, the competency-based education focuses and explicitly defines the competencies with the curricular outcomes, application of knowledge rather than acquisition, and that every resident is ready for practice. It emphasizes on the abilities or competencies over long list of knowledge objectives. A de-emphasis of time-based training to better resident's ability to perform. Promoting the process of learner-centeredness instead of teacher-centeredness and encourages residents to take responsibility for their progress and development to the way of competence.³ It emphasizes on formative and on-going feedback rather summative feedback at the end of rotation,^{5,12} and includes direct assessment on observation of real task of profession instead of proxy assessment.¹²

Challenges of Competency-based education in Pakistani Context: The Islamic Republic of Pakistan inherited the common British health and medico legal systems, but variable levels of education and infrastructure.¹³ Health care institutions are in deficit and lack the trained manpower for training residents for modern day and outcome-based performance. Currently, many countries are in a phase of revisiting their postgraduate medical training programs, particularly those based on British systems of education. The valuable contribution made by the College of Physicians and Surgeons of Pakistan (CPSP) for moving to competency-based postgraduate training for residents and trainees within the country needs to be appreciated.

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Received August 09, 2011; accepted April 16, 2012.

This transition from Flexner to competency-based education will involve a number of challenges and perhaps need a visionary strategic planning for wide adaptability of the competency model at the national level. Understanding of the importance and confidence in the principles of this model is the foremost challenge toward its implementation.³ The support of higher leadership and key faculty champions of training institutions is vital for its success and implementation. Also, the core challenge involves faculty development, training of the faculty to become experts in the competencies and in the use of innovative assessment tools for valid and reliable assessment of the residents' competencies.⁵ Achievement of the faculty development objective needs true engagement, motivation and dedication on the part of the faculty as well as the residents.

The competency-based model provides an exceptional opportunity and at the same time demands assurance from residents to have acquired the desired level of competence to be accountable to patients and the nation.⁹

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ERRATA

An error was noticed in our publication titled “**Chronic Gastritis and Helicobacter pylori: A Histopathological Study of Gastric Mucosal Biopsies**” by Mohammad Yawar Yakoob and Akbar Shah Hussainy in JCPSP 2010, Vol. 20 (11): 773-775. The terms “retrospective cohort”, on page 773 in 3rd paragraph of the page, first line, should be read as “cross-sectional”. The error is regretted

There was a discrepancy in the affiliation/work place of a co-author, Dr. Nasrin Fouladi, in the article titled “**Profile of Acute Carbon Monoxide Poisoning in the West Province of Iran**” by Mitra Yari, Nasrin Fouladi, Habib Ahmadi and Farid Najafi published in JCPSP 2012, Vol. 22 (6): 381-384.

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Editor